The Waiver Application

- Back in the good old days—or bad old days depending on your perspective—there was no waiver application, just a set of statutes
- In 1990, CMS published a waiver template that was about 25 pages
- In 1995, a new version was published that was about 35 pages
- And now…

The Waiver Application

- We have a 324 page guide to filling out the CMS application which is 98 pages (when blank) with 10 Appendices
- The application is Web based
- The current Version 3.5 Application and accompanying Technical Guide are found at:

  https://wms-mmdl.cdsvdc.com/WMS/faces/portal.jsp
- The Technical Guide clarifies many important CMS policies and provides *the* source of guidance for filling out a waiver application

Waiver Application

- The application has 10 Appendices
  - **Appendix A: Waiver Administration and Operation**
  - **Appendix B: Participant Access and Eligibility**
  - **Appendix C: Participant Services**
  - **Appendix D: Participant-Centered Planning and Service Delivery**
  - **Appendix E: Participant Direction of Services**
  - **Appendix F: Participant Rights**
  - **Appendix G: Participant Safeguards**
  - **Appendix H: Quality Management Strategy**
  - **Appendix I: Financial Accountability**
  - **Appendix J: Cost Neutrality Demonstration**

And within each Appendix…

- The state must describe who does what and how the state will meet all the requirements of the HCBS waiver program
- Performance measures on six key assurances and 12 “sub-assurances” that the state must agree to
- This includes describing
  - Methods for discovering if the state is meeting the requirement (*discovery*) which includes data collection, sampling methods and analysis to demonstrate compliance with assurances
  - *Remediation* of issues discovered
  - System *improvement*

Appendix A: Waiver Administration and Operation

- It's about who runs what
- The Single State Medicaid Agency must always retain "oversight" of the program and monitor any other agency operating the program
- The DD agency can run the day-to-day operations
- And other operations can be delegated to state regional offices, counties or contracted agencies at the state's discretion

Appendix A: Waiver Administration and Operation

- ***Assurance # 1:***

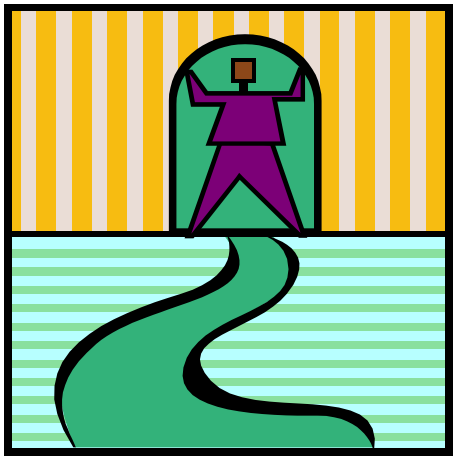
"The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities "

Appendix B: Participant Access and Eligibility

States Without Public or Private Facilities/Institutions (>16 beds) include:	
District of Columbia	1991
Vermont	1993
Maine	1996
New Mexico	1997
Hawaii	1999
Oregon	2009
Alabama	2011

- Who is eligible
- Individual cost limits, if any
- Number of people served by the waiver
- "Reserved" waiver capacity
  - Can designate waiver "slots" for certain groups or purposes such as deinstitutionalization or school transition
- Freedom of choice
  - Individuals have the right to choose HCBS or institutional services—but that does not mean a state has to operate institutions!

Appendix B: Participant Access and Eligibility



- ***Assurance # 2:***

"An evaluation for Level of Care is provided to all applicants for whom there is reasonable indication that services may be needed in the future."

Appendix C: Participant Services

- CMS provides a list of Core Services
- States can use, modify, add to, invent new or ignore these definitions
- Cool things you can do:
  - Cover customized employment
  - Pay for transition costs for people moving from congregate settings (including group homes!) to their own homes
  - Pay for lots of non-traditional supports and services for individuals who self-direct under “Individual Directed Goods and Services’ (more about this later…)

Appendix C: Participant Services

- States decide the provider qualifications
- CMS rules allow relatives and family to provide services, including parents of children-states have discretion about who can and can't provide services*
- CMS has set some criteria for paying legally responsible relatives for personal care, for example:
  - Care must be "extraordinary care," exceeding the ordinary care that would be provided to a person without a disability of the same age;
  - How it is established that the provision of personal care or similar services by a legally responsible individual is in the best interests of the participant?

See: Cooper, Robin, *"Caring Families…Families Giving Care Using Medicaid to Pay Relatives Providing Support to Family Members with Disabilities",* NASDDDS, Inc., June, 2010
http://www.nasddds.org/Publications/PubsOrderForm.pdf

Appendix C: Participant Services

- ***Assurance # 3:***

  The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services

Appendix D: Participant-Centered Planning and Service Delivery

- Service Plan Development
  - CMS notes that it is important that the participant can include individuals of his/her choice in the service plan development process
  - Information and supports must be available to the participant (or others designated by the participant) to actively engage in and direct the process.
- Service Plan Implementation and Monitoring
  - Participants have understandable information about choice of qualified providers and available service providers.
  - Participants are supported in selecting providers

Appendix D: Participant-Centered Planning and Service Delivery

- **Assurance # 4:**

  Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

Appendix E: Participant Direction of Services

CMS says…

“ *Participant direction of waiver services means that the waiver participant has the authority to exercise decision making authority over some or all of her/his waiver services and accepts the responsibility for taking a direct role in managing them.”*

Two Basic Approaches

- **Participant Employer Authority**

and/or

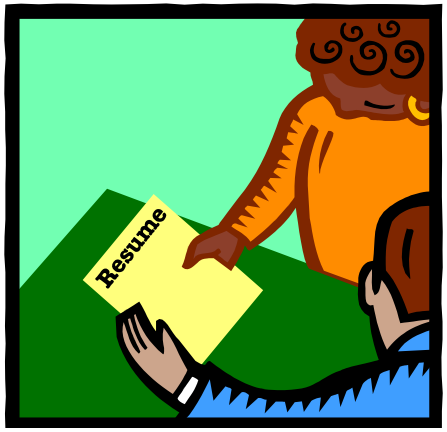
- **Participant Budget Authority**

Employer Authority

- The waiver participant—or family/guardian or representative—**not** an agency oversees the support workers
  - **Co-Employment**. An agency employs workers recruited by the participant.
  - **Common Law Employer**: The participant is the legally responsible employer of workers whom he or she (or his or her representative) hires, supervises and discharges directly.

Employer Authority means:

- The participant (or representative) has the power to
  - Recruit workers
  - Hire and fire staff (common law employer) or
  - Refer to the agency for hire and discharge from providing services (co-employer)
  - Decide on staff qualifications
  - Decide staff duties
  - Schedule staff
  - Supervise staff
  - Evaluate staff performance



Budget Authority

- Budget Authority means the person has to:
  - Determine the amount paid for each service in accordance with the state's policies
  - Schedule when services are provided
  - Identify service providers and refer for enrollment
  - Review and approve provider invoices

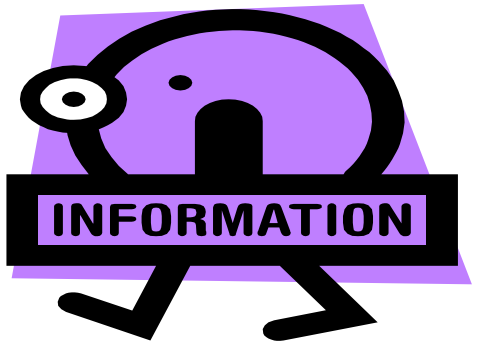
(Psst….you can allow for this for *all* services, not just under self-direction!)

Determining Budgets

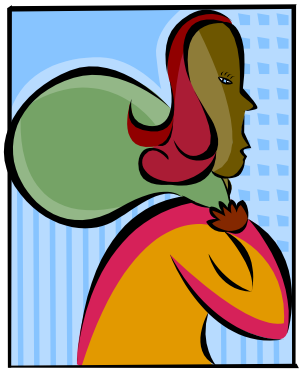
- CMS requires that if the state is using individuals budgets, everyone must understand:
  - The method used for determining participant-directed budget.
  - How the method relates to the person's service plan.
  - The state must "spell-out" how the budget is determined.

Determining Budgets

- Everyone must understand:
  - How information about the budget methodology is made publicly available
  - How the method is applied consistently to each waiver participant.



Financial Management Services (FMS)



- The HCBS waiver does not allow states to give individuals cash directly.
- Can give the money to an agency or organization (FMS) that “keeps the books” on behalf of the person
- Person has full control over the money but the FMS does the paperwork and pays the bills.

Supports Brokering

- Support for individuals (Supports brokering) to self-direct must be available if needed, but:
  - *Not required if people don't need it*
  - Can be done many different ways-- by individuals, agencies or organizations as decided on by the state and stakeholders

Interesting option available under waivers with participant-direction …

- ***Individual Directed Goods and Services*** *(IDGS) are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the service plan (including improving and maintaining the participant's opportunities for full membership in the community).*

IDGS must meet requirements that:

- *The item or service would decrease the need for other Medicaid services;*
- *AND/OR promote inclusion in the community;*
- *AND/OR increase the participant's safety in the home environment;*
- *AND, the participant does not have the funds to purchase the item or service or the item or service is not available through another source.*
- *Experimental or prohibited treatments are excluded.*

Appendix F: Participant Rights

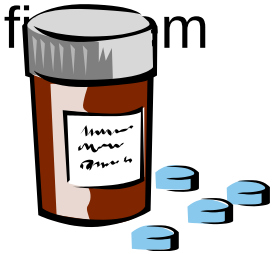
- Opportunity for Medicaid Fair Hearing
  - Individuals can request Fair Hearing for any reduction, termination of services or other State actions regarding Medicaid services
- Additional Dispute Resolution Mechanism
  - State can offer other mediation options
- State Grievance/Complaint System

….but nothing can stand in "front" of Fair Hearing, that is the state cannot require someone go through another process before using a Fair Hearing

Appendix G: Participant Safeguards

- **Response to Critical Incidents or Events -** must describe the system for dealing with abuse, neglect and other incidents *and* training for everyone—including family members

- **Safeguards Concerning Restraints and Restrictive Interventions-*IF*** the state uses them
- **Medication Management and Administration**-includes review of behavior-modifying meds, how the state will discover harmful practices-and fi m



Appendix G: Participant Safeguards

- Assurance # 5:

  The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation

Appendix H: Quality Management S

- This section is all about how the state assures CMS you meet all requirements…and how you make improvements in your system

- CMS requires states to collect and analyze data that demonstrate your system is in compliance with CMS regulations and the waiver assurances

Appendix H: Quality Management Strategy (QMS)

- Quality Management includes, for each of the six assurances:
  - The evidence based *discovery* activities that will be conducted for each of the six major waiver assurances;
  - The *remediation* processes followed when problems are identified in the implementation of each of the assurances;
  - The *system improvement* processes followed in response to aggregated, analyzed information collected on each of the assurances;
  - The correspondent *roles/responsibilities* of those conducting discovery activities, assessing, remediating and improving system functions around the assurances; and
  - The process that the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate

Appendix I: Financial Accountability

- Appendix I covers the various financial integrity assurances and practices that the state must agree to to get federal funds like:
  - Using only “legal “ matching funds
  - Subjecting the programs to audits
  - Explaining how rates are set
  - Not paying for room and board

- **Assurance # 6:**

  State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver

Appendix J: Cost Neutrality Demonstration

- Appendix J is the “formula” that shows what the state will spend on average per person will not be more than what it would have cost on average per person for institutional care

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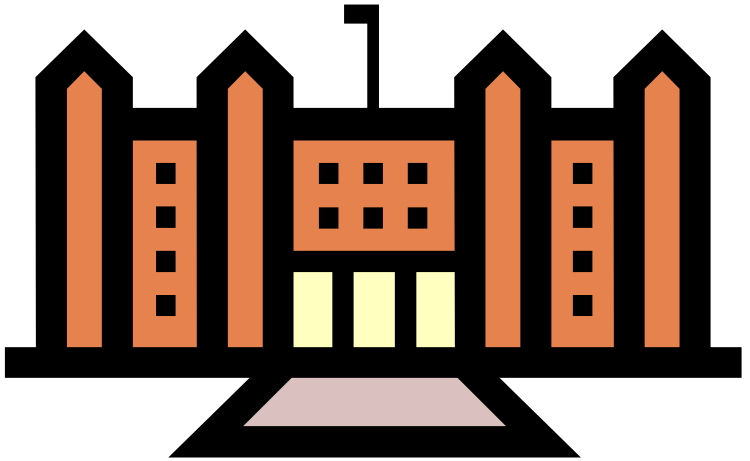

So there are LOTS of things you can do…

- Write multiple waivers for different groups and sets of services
- Cap the amount of services or the dollars available to individual participants
- Define your own services
- Define your own provider standards
- Allow legally responsible relatives to provide services
- Use participant-directed approaches

Just a few ideas…

- The state proposes
- CMS negotiates and approves
- So good advice is:
  - Ask for what you want the way you want it to be
  - Take advantage of the flexibility of the waiver regulations to tailor your waiver to the needs and preferences of your citizens